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AMERITAS®
LIFE INSURANCE CORP.

A STOCK COMPANY
LINCOLN, NEBRASKA

The Policyholder **NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM**

Group Policy Number **G010-350308**

Policy Effective Date **January 1, 2003**

Ameritas Life Insurance Corp. certifies that it has issued to the Policyholder the group policy shown above. Such policy insures certain persons for benefits described in the following pages. The benefits shown are subject to all the terms of the group policy which has been issued to the Policyholder.

The group policy may be amended or cancelled without the consent of the insured person.

This certificate replaces all certificates previously issued to the insured person under said policy.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

Certain insurance benefits payable under the policy may be combined with the benefits payable under other plans or programs so that the total reimbursement for allowable expenses does not exceed the actual expenses incurred. Those benefits subject to this provision are: *VISION*

"NOTICE OF TEN-DAY RIGHT TO EXAMINE CERTIFICATE"

You are urged to read this certificate carefully. If, after examination, you are dissatisfied with it for any reason, you may return it to the selling agent or Ameritas Life Insurance Corp. at P.O. Box 81889, Lincoln, NE 68501-1889 within ten days from the date of delivery of the certificate to you. If you do return the certificate, any premium paid will be refunded and it shall be considered void from its effective date as if it was never in force.

JoAnn M Martin

President

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SCHEDULE OF BENEFITS

The Personal Insurance for each Insured and the Dependent Insurance for each of the Insured dependents will be according to the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	All Eligible Employees & Dependents All Eligible Retirees

PERSONAL AND DEPENDENT VISION CARE INSURANCE	Each Individual
VISION CARE BENEFITS	
Deductible Amount - Frames/Contact Lenses - Once Per Lifetime	$ 40

ELIGIBILITY

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee or their dependent meets the criteria for eligibility, a membership application must be completed.

Personal Insurance

A member of the Eligible Class for Personal Insurance is any permanent employee who is employed by a governmental unit as that term is defined in 54-52-01 of the North Dakota Century Code (NDCC). State employees who are eighteen (18) years of age whose services are not limited in duration, who are filling an approved and regularly funded position, and who are employeed at least 17 and one-half hours per week at least five months each year or those first employed after August 1, 2003, are employed at least twenty (20) hours per week and at least twenty weeks each year of employment are eligible to receive benefits. An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment. As an eligible employee, you will be provided with an application when you become eligible for coverage. Each eligible employee may elect to enroll his/her Eligible Dependents.

Individual employees of non-participating Political Subdivisions and part-time or temporary employees are NOT eligible for benefits.

Dependent Insurance

A member of the Eligible Class for Dependent Insurance is any person who is the Insured's spouse or qualified dependent(s) as provided for in the plan.

SCHEDULE OF BENEFITS
(Continued)

Retiree Insurance

A Member of the Eligible Class for Retiree Insurance is an individual who is entitled to a retirement allowance as defined in NDCC 54-52.1-03 Retirees or surviving spouses who are under age 65 and are receiving a retirement benefit from the Public Employees Retirement System, the Highway Patrolmen's Retirement System, the Teachers' Insurance and Annuity Association of America-CollegeRetirement Equities Fund (TIAA-CREFF), the Job Service Retirement System, Judges' Retirement System, the Teachers' Fund for Retirement (TFFR), or retirees who have accepted a retirement allowance from a participating political subdivision's retirement plan are eligible for benefits. An eligible retiree or surviving spouse is entitled to coverage the first of the month following the month of retirement or enrollment due to a qualifying event. Should you retire prior to age 65, or when you or any dependent covered under your coverage becomes eligible for Medicare you must contact the NDPERS Office for further information by writing: NDPERS, Box 1657, Bismarck, ND 58502 or by calling 701-328-3900 or 1-800-803-7377.

When a Member of the Eligible Class for Personal Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased Member will continue to be listed as a Member of the Eligible Class for Dependent Insurance. This will allow the dependents of the deceased Member to continue the insurance for the limited period following death in accordance with the provision, Death of Insured Person, as stated in this SCHEDULE OF BENEFITS under CONTINUATION OF COVERAGE.

WAITING PERIOD

For Members on the Effective Date of the policy, no waiting period is required.

For persons who become Members after the Effective Date of the policy, no waiting period is required.

CONTRIBUTION
Personal Insurance

An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance

An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SCHEDULE OF BENEFITS
(Continued)

CONTINUATION OF COVERAGE

An employee or dependent whose insurance has stopped may be able to continue some or all of the insurance coverages. The sections below explain when and how insurance may be continued. If insurance is continued, it must be according to a plan which does not allow individual selection.

Federally Required Continuation
For Employees and/or Dependents

Through the Consolidated Omnibus Budget Reconciliation Act (COBRA) the federal government requires the Policyholder to provide continuation of coverages to employees and/or dependents who would otherwise lose their coverages. There are some groups which are not subject to the law. They are:

1. groups of less than 20 employees.
2. certain church plans.

For details the employee and/or dependent(s) must contact the person who handles the Policyholder's insurance matters.

Family and Medical Leave Act
For Employees Only

If the Insured is on leave from active work as certified by a physician and the employer, then for the purposes of eligibility, the Insured will be considered to be actively at work. Coverage will remain in force so long as the requirements of the FMLA continue to be met and the Insured continues to contribute to the payment of the insurance premiums.

DEFINITIONS

Company is Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is One Ameritas Way, P.O. Box 81889, Lincoln, Nebraska 68501-1889.

POLICYHOLDER means the Policyholder stated on the face page of the policy and the Associated Groups, if any, as listed in "Premiums".

INSURED means a person:

a. who is a Member of the Eligible Class for Personal Insurance; and

b. who has qualified for insurance by completing the waiting period, if any; and

c. for whom the insurance has become effective.

MEMBER means a person as defined within the Benefit Class.

DEPENDENT INSURANCE means insurance which provides benefits payable as a result of the treatment of a dependent of an Insured.

DEPENDENT means:

a. an Insured's spouse.

b. each unmarried child less than 23 years of age for whom the Insured is legally responsible, to include:

   i. natural born children, including a dependent of an unmarried child;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 23 but less than 26 who is:

   i. a full-time student at an accredited school or college; and

   ii. primarily dependent on the Insured for support and maintenance.

d. each unmarried child age 23 or older, including a dependent of an unmarried child, who:

   i. is totally disabled due to mental or physical reasons; and

   ii. becomes totally disabled while insured as a dependent under b or c above; and

   iii. is entirely dependent on the Insured for support and maintenance.

DEPENDENT UNIT means all of the people who are insured as the dependents of any one Insured.

FAMILY means an Insured and all of the Members of his or her dependent unit.

ACTIVE SERVICE means the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full-time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

PERSONAL INSURANCE means insurance which provides benefits payable as a result of the treatment of an Insured.

PHYSICIAN means any person who is licensed by the law of the state in which treatment, within the scope of his or her license, is given for the sickness or injury causing the expenses or loss for which claim is made.

LATE ENTRANT means any person:

a. whose Effective Date of insurance is more than 31 days from the date the person qualifies for insurance, or

b. who has elected to become insured again after cancelling coverage.

CALENDAR YEAR means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a calendar year means the period from his or her effective date through December 31 of that year.

EFFECTIVE DATE means the date coverage under the policy becomes effective. The Effective Date for the Policyholder is shown on the policy cover. The Effective Date for an Insured is shown on the individual certificate or is in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

CONDITIONS FOR PERSONAL INSURANCE

ELIGIBILITY

ELIGIBLE CLASS FOR PERSONAL INSURANCE. The Members of the Eligible Class for Personal Insurance are shown on the Schedule of Benefits.

WAITING PERIOD. The Waiting Period is shown on the Schedule of Benefits.

If employment is the basis for Membership in the Eligible Class for Personal Insurance (referred to here as "Membership"), an Insured whose eligibility terminates and is established again within 12 months will not have to complete a new waiting period before he or she can again qualify for insurance.

CONTRIBUTION REQUIREMENTS. Whether or not an Insured must contribute to the payment of insurance premiums is shown in the Schedule of Benefits.

EFFECTIVE DATE

The Effective Date for each Member will be:

1. the first day of the month following the month of permanent employment provided the Member submits an application for coverage within the first 31 days of employment.

2. the date we accept the Member for insurance when the Member is a Late Entrant. The Insured will be subject to any limitation concerning Late Entrants.

EXCEPTIONS. If employment is the basis for Membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. For this paragraph, a Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If Membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATE

The insurance on any Insured will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;

2. the last day of the period for which the Insured has contributed to the payment of insurance premiums; or

3. the date the policy is terminated.

CONTINUATION OF COVERAGE. If an Insured's coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. See the Schedule of Benefits.

CONDITIONS FOR DEPENDENT INSURANCE

ELIGIBILITY

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. The Members of the Eligible Class for Dependent Insurance are shown on the Schedule of Benefits.

Each Member of the Eligible Class for Dependent Insurance (referred to here as "Member") is eligible for the Dependent Insurance (referred to here as "Insurance") under the policy and will qualify for this insurance on the latest of:

1. the day he or she qualifies for Personal Insurance;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent.

A Member must be insured for Personal Insurance to insure his or her dependents.

CONTRIBUTION REQUIREMENT. Whether or not an Insured must contribute to the payment of insurance premiums for his or her dependents is shown in the Schedule of Benefits.

EFFECTIVE DATE

The Effective Date for the dependents of each Insured will be the first of the month falling on or next following:

1. the date on which the Insured qualifies for insurance, if the Insured agrees to contribute on or before that date.

2. the date we accept each dependent for insurance when the dependents are Late Entrants. Each dependent will be subject to any limitation concerning Late Entrants.

CONDITIONS FOR RETIREE INSURANCE

ELIGIBILITY

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. The Members of the Eligible Class for retiree Insurance are shown on the Schedule of Benefits.

Each Member of the Eligible Class for Retiree Insurance (referred to here as "Member") is eligible for the Retiree Insurance (referred to here as "Insurance") under the policy provided the retiree submits an application within 31 days from any one of the following "qualifying events."

1. Date of retirement which is the last day of active employment or date of first retirement check;
2. Retiree's 65th birthday or eligibility for Medicare;
3. Retiree's spouse's 65th birthday or eligibility for Medicare;
4. The last date of coverage in a vision plan provided by the retiree's or spouse's employer. This includes loss of coverage due to death of, or divorce from a spouse as well as the completion of COBRA continuation coverage;
5. Marriage; or
6. Birth, adoption, or legal guardianship.

If a Member fails to enroll within 31 days of any one of the above qualifying events, a Member will have forfeited the right to enroll in the plan in the future.

A Member must be insured for Personal Insurance to insure his or her dependents.

TERMINATION DATE

The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's Personal Insurance terminates;

2. the date on which the Insured ceases to be a Member;

3. the last day of the period for which the Insured has contributed to the payment of insurance premiums; or

4. the date all Dependent Insurance under the policy is terminated.

The insurance for any dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent does not meet the definition of a dependent. See "Definitions".

CONTINUATION OF COVERAGE. If a dependent's coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. See the Schedule of Benefits.

PERSONAL AND DEPENDENT VISION CARE INSURANCE

VISION CARE EXPENSE BENEFITS

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses shall be the lesser of:

a. the charge for services or supplies furnished; or

b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Vision Procedures.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid for only those Covered Expenses which are more than the deductible amount.

COVERED EXPENSES. Covered Expenses means the Vision expenses incurred by an Insured for the procedures shown in the Schedule of Vision Procedures, up to the Maximum Covered Expense shown for each procedure. But such expenses will be Covered Expenses only to the extent that they are incurred for procedures done by a physician, optometrist, or optician. These expenses are subject to the "Limitations" below.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Should an Insured's coverage under this section terminate, we will pay Covered Expenses for frames or lenses which were ordered while coverage was in force, provided such frames or lenses are delivered within 30 days from the date the Insured's coverage ceases.

LIMITATIONS. Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. Vision examinations more than once in any 12 month period, based on date of service
2. Prescribed lenses more than once in any 12 month period, based on date of service.
3. Frames more than once in any 12 month period, based on date of service.
4. Contact lenses more then once in any 12 month period, based on date service. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the 12 month period, based on date of service. When lenses and frames are chosen, expenses for contact lenses are not Covered Expenses during the 12 month period, based on date of service.
5. Examinations performed or frames or lenses ordered before the Insured was covered under this section.
6. Subject to Extension of Benefits, any examination performed or frame or lens ordered after the Insured's coverage under this section ceases.
7. Sub-normal vision aids; orthoptic or vision training or any associated testing.
8. Non-prescription lenses.
9. Replacement or repair of lost or broken lenses or frames except at normal intervals.
10. Any eye examination or corrective eyewear required by an employer as a condition of employment.
11. Medical or surgical treatment of the eyes.
12. Any service or supply not shown on the Schedule of Vision Procedures.
13. Lenses and frames during the first twelve months that a person is insured under this section, when the person is a Late Entrant, as defined.

SCHEDULE OF VISION PROCEDURES

The following is a complete list of vision care services for which benefits are payable. No benefits are payable for a service which is not listed.

SERVICE	MAXIMUM COVERED EXPENSE
Vision Examination	$35.00
May consist of, but not limited to, the following: case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance testing; tonometry test for glaucoma, when indicated; gross visual fields, when indicated; color vision testing when indicated; summary finding; prescribing of lenses.	
Frames	40.00
Lenses	
Single Vision	35.00
Bifocal	50.00
Trifocal	65.00
No line bifocal or progressive power	70.00
Lenticular	70.00
Contact Lenses	75.00

COORDINATION OF BENEFITS

If an Insured is also covered under one or more other Plans, the benefits payable under this Plan will be coordinated with the benefits payable under those Plans.

BENEFITS SUBJECT TO COORDINATION. All vision benefits covered under two or more Plans will be coordinated.

EFFECT ON BENEFITS. When coordination applies, we adjust the benefits payable for any Claim Determination Period (period) as follows. The benefits that would be payable for Allowable Expenses incurred in that period under this Plan without coordination are reduced so that the sum of those reduced benefits and the benefits payable for those Allowable Expenses under all other Plans, whether or not claim is made, will not exceed the Allowable Expenses.

If, when we coordinate the benefits of this Plan with those of another Plan, (1) the rules set forth below would require this Plan to set its benefits before the other Plan; and (2) the other Plan coordinates benefits and would set its benefits after the benefits of this Plan have been set; then the benefits of that other Plan will be ignored when setting the benefits of this Plan.

ORDER OF BENEFIT DETERMINATION. The rules used to determine which of the Plans will pay benefits first are:

1. The benefits of a Plan with no coordination will set its benefits before a Plan with coordination.

2. The benefits of a Plan which covers the person other than as a dependent will be set before the benefits of a Plan which covers that person as a dependent.

3. If the claim is made for a dependent child whose parents are not separated or divorced, the benefits of a Plan that covers a child as a dependent of a person whose month and day of birth occurs earlier in a calendar year will be set before the benefits of a Plan that covers that child as a dependent of a person whose month and day of birth occurs later in a calendar year.

   If the month and day of birth of both parents is the same, then the Plan which has covered the parent for the longer period of time will pay its benefits first.

   If the other plan has a rule based on gender of the parent and, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

4. If the claim is made for a dependent child whose parents are separated or divorced, benefits for the child are determined in this order.

   a. first, the Plan of the parent with custody of the child;

   b. then, the Plan of the spouse of the parent with custody of the child; and

   c. finally, the Plan of the parent not having custody of the child.

   But, if there is a court decree which sets financial responsibility for the vision expenses for the child, the benefits of a Plan which covers the child as a dependent of the parent who is responsible shall be set before the benefits of any other Plan which covers the child as a dependent child.

5. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) will be set before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of the benefits, then this rule is ignored.

6. When the rules above do not apply, the benefits of a Plan which has covered the person for the longer period of time will be set before the benefits of a Plan which has covered the person the shorter period of time.

When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may give or get from any other organization or person any information necessary to decide whether coordination applies. This may be done without the consent of the Insured. Any person claiming benefits under this Plan will be required to give us any information necessary to coordinate benefits. Any information received and maintained will be in a manner consistent with all applicable state and federal laws.

FACILITY OF PAYMENT. When other Plans make payments which should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made.

DEFINITIONS. The following apply only to this provision of the policy:

1. "Plan" means any of these types of coverage providing vision benefits or services:

    a. group insurance or group type coverage, whether insured or uninsured. This includes:

        i. Blue Cross and Blue Shield.

        ii. blanket (other than school accident-type coverage) and franchise insurance.

        iii. Health Maintenance Organizations (HMO's).

        iv. other prepayment, group practice and individual practice plans.

    b. any coverage under a governmental plan or required or provided by law, except Medicaid.

    Each type of coverage in a. or b. above is a separate Plan. If an arrangement has two or more parts and this coordination applies to only one part, each of the parts is a separate plan.

2. "Allowable Expense" means any necessary, reasonable and customary expense at least a part of which is covered under at least one of the Plans covering the person for whom claim is made.

    When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be both an Allowable Expense and a benefit paid.

3. "Claim Determination Period" means a calendar year or that part of a calendar year during which the person for whom claim is made has been covered under this Plan.

GENERAL PROVISIONS

NOTICE OF CLAIM/PROOF OF LOSS. Written notice of claim or proof of loss must be given to us within 90 days after the event on which claim or proof of loss is based.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured.

FACILITY OF PAYMENT. If an Insured is not capable of giving us a valid receipt for any payment and if no request for payment has been made by a legally appointed guardian, we may, at our option, pay the Insured or any person or institution appearing to us to have assumed the custody of and principal support of the Insured.

If an Insured dies while vision benefits are unpaid, we may, at our option, pay the person or institution on whose charges claim is based, any Member of the Insured's immediate family or the Insured's estate.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PHYSICIAN-PATIENT RELATIONSHIP. The Insured will have free choice of any physician practicing legally. We will in no way disturb the physician-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. We cannot contest the validity of the policy after one year from the date of issue except for non-payment of premiums. We cannot contest an Insured's insurability after his or her insurance has been in force for one year while the Insured is alive. Any of the insured's statements that we contest must be in a written application signed by the Insured.

WORKER'S COMPENSATION. The policy does not satisfy any requirements for coverage of worker's compensation insurance.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

A resident of North Dakota who purchases life insurance, annuities or accident and health insurance should know that an insurance company licensed in this state to write these types of insurance is a member of the North Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyowner will be protected, within statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for your care in selecting a company that is well-managed and financially stable.

The North Dakota Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Dakota. You should not rely on coverage by the North Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus or self-funded plan.

Your insurance company or its agent is required by law to give or send you this notice. ***However, your insurance company and its agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.***

Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, NE 68501-1889
1-800-745-6665

The North Dakota Life and Health Insurance Guaranty Association
P.O. Box 8875
Fargo, North Dakota 58109-8875

State of North Dakota Department of Insurance
600 East Boulevard Avenue, Dept 401
Bismarck, North Dakota 58505

The state law that provides for this safety-net coverage is called the North Dakota Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change your rights or obligations under the act or the rights or obligations of the guaranty association.

(please turn to back of page)

COVERAGE

Generally, an individual will be protected by the life and health insurance guaranty association if the individual lives in North Dakota and holds a life or health insurance contract or annuity contract, or if the insured is insured under a group insurance contract issued by a member insurer. A beneficiary, payee or assignee of an insured person is protected as well, even if a non-resident of North Dakota.

EXCLUSIONS FROM COVERAGE

However, a person holding such a policy is **not** protected by this association if:

* the individual is eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
* the insurer was not authorized to do business in this state;
* the policy is issued by an organization which is not a member of the North Dakota Life and Health Insurance Guaranty Association. Health maintenance organizations fraternal benefit societies and the Comprehensive Health Association of North Dakota are not members of the guaranty association.

The association also does **not** provide coverage for:

* policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
* policy of reinsurance (unless an assumption certificate was issued);
* an interest rate yield that exceed an average rate;
* a dividend;
* an credit given in connection with the administration of a policy by a group contractholder;
* an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how may policies and contracts were in force with the same company, even if the policies provided different types of coverages. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: for unallocated annuities that fund governmental retirement plans under §§ 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $100,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contractholder, regardless of the number of contracts held with the same company or number of persons covered. In all cases the contract limits also apply.

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone - (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number.

Internal Formal Grievance Procedures

In accordance with Section 26.1-36-42 of the North Dakota Century Code

Ameritas Life Insurance Corp.
5900 "O" Street
Lincoln, NE 68510

I. Definitions

"Grievance" means a written complaint submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding:

(a) the availability, delivery, or quality of dental or vision care plan services;

(b) benefits or claims payment, handling, or reimbursement for dental or vision care services.

II. Designated Person Responsible For Complaint System and Receiving Complaints

Name: Raymond M. Gilbertson
Vice President - Corporate Compliance

Address: P.O. Box 82657
Lincoln, NE 68501-2657

Phone: 800-487-5553
Fax: 402-467-7883

III. Complaint Procedures

A. Providing Notice

Any persons making a verbal complaint, in person or by telephone, will be instructed to document their concerns in writing and to forward their documentation to the Complaint Officer, Kenneth R. Jones. Any complaints received in writing will be forwarded to the appropriate area for review.

B. Internal Review

The complaint will be reviewed by all appropriate internal parties. The complainant will be kept appraised as to the status of the complaint in a timely fashion. In no event however, will the final determination be made no later than 30 calendar days after receiving the formal written grievance.

The complainant also has the right to present their grievance at a managerial level conference.

C. Decision

a. Denial Upheld

If we continue to agree that the covered service or claim for a covered service should have been denied, the complainant will receive a written notice of that decision. The complainant will also receive a notice of their right to appeal the decision to the State Insurance Department.

b. Denial Reversed

If we agree that the covered service should have been provided, or that the claim should have been paid, we will authorize the service or pay the claim.

IV. Complaint Records

A. Complaint Log

All written complaints and grievances will be logged and maintained within the corporate complaint file system.

A coding system is established to assign complaint codes to each file to track the nature of the complaint or grievance. A summary of the number and types of complaints filed will be compiled annually. This assists management in a periodic review of the type and nature of the complaints received to ensure that appropriate actions are being taken.

B. Insurance Department Review

Copies of all complaint files, including responses are available at our home office for review by the various state insurance departments for a minimum of 3 years following the year that the complaint was received.